Level 8, 111 Customhouse Quay, Wellington
Phone: 04 912 2642 Fax: 04 901 0920

CENTRAL WELLINGTON MEDICAL CENTRE

ENROLMENT FORM

I intend to use Central Wellington Medical Centre as my regular and ongoing provider of General Practice/GP/First level primary health care services. I am eligible to enrol in the Compass PHO because I am permanently residing in New Zealand and are a New Zealand Citizen ☐ *(please tick if applies or enter criteria letter below)*

OR meet one of the criteria laid out in the Eligibility Guide, with the corresponding letter: ☐

Title	Miss ◯ Mrs ◯ Ms ◯ Mr ◯ MAST ◯	**NHI**	
First name		**Last name**	
Middle name		**Previous name**	
Gender	◯ Female ◯ Male ◯ Gender Diverse *(please state)*		
Date of Birth		**Occupation:**	
Country of Birth		**Place of Birth**	
Contact details	*Home* / *Work*	*Cell*	
Email Address		**Can we text you?** ◯	**Can we email you?** ◯

Physical address	**Postal address** (*if different to physical address*)
Street *Suburb*	*Street* *Suburb*
City / *Postcode*	*City* / *Postcode*

Community Services Card	**Y / N**	***Exp:*** / /	**High User Card**	**Y / N**	***Exp:*** / /
	#:			**#:**	

Smoking Status ***(please circle)***	Non-smoker	Current Smoker	Ex-Smoker
Next of kin	***Full Name:***	***Relationship:***	***Contact Number:***

Which ethnic group do you belong to? Tick as many as apply to you

☐ NewZealand European(11)	☐ Maori (21) – Iwi:	☐ Niuean	☐ Cook Island Maori	☐ Indian (43)
☐ Other Eurpoean (12)	☐ Samoan (31)	☐ Chinese (42)	☐ Tongan	☐ Other (please state: e.g Dutch, Japanese, Tokelauan)

Patient Declaration

- **I have read and agree** to the terms in the Health Information Privacy Statement. The information I have provided on this form will be used to determine eligibility to receive publicly funded services. Information may be compared with other government agencies but only when permitted under the Privacy Act.
- **I confirm** that if requested I can provide proof of my eligibility. **I agree** to inform the Practice of any changes in my eligibility.
- **I understand** that by enrolling with this Practice, I will be enrolled with the Primary health Organisation (PHO) this Practice belongs to and my name, address and other identification details will be included on both the Practice and the PHO Enrolment Register.
- **I understand** that if I visit another Provider where I am not enrolled, I may be charged a higher fee and that by registering as a patient I am agreeing to the practices finance policy of which a full copy is available from reception or on the website.
- **I have been given** information about the benefits and implications of enrolment with the PHO, and their contact details.
- **I understand** that the Practice participates in a national survey about people's health experience and how their overall care is managed. Taking part is voluntary and all responses are anonymous. I can decline the survey or opt out of the survey by informing the practice. The survey provides important information that is used to improve health services.

SIGNATURE		**DATE**	
SIGNED AUTHORITY		**DATE and relationship to patient.**	

TRANSFER OF NOTES	**Please obtain my notes from my previous Doctor. I understand I will be removed from their register.**
Name of Previous Doctor:	**SIGNATURE:**

Please send to : CENTRAL WELLINGTON MEDICAL, PO BOX 362, WELLINGTON 6140
Or Electronically: EDI is CWMEDCEN. Dr Jacob Tan 59591 Dr Nick Duffy 13038

CENTRAL MEDICAL CENTRE NEW PATIENT QUESTIONAIRE

This questionnaire is to help us obtain information for the purpose of health screening and to help us provide you with the best possible medical care. The questionnaire is STRICTLY CONFIDENTIAL. If you do not wish to answer the questions or have your information used for screening purposes please let our staff know.

Do you have any allergies or reactions to medications?
YES / NO **Please specify**: _____

SMOKING: Have you ever smoked? **YES / NO**
If you are an Ex-smoker when did you quit? _____
Do you currently smoke? **YES / NO**
Number per day? _____ Number of years ____

Quitting smoking is the best thing you can do to improve your health. Would you like someone from the practice to contact you to discuss quitting options? (Patches, gum, tablets, and support services) **YES / NO**

ALCOHOL: Do you drink alcohol? **YES / NO**
If YES – Type? _____
Units per week? _____
Do you have at least two alcohol free days a week? **YES / NO**

Weight if known:

Height if known:

Anything else you would like us to know?